Health Issues Facing the Aging Woman

The U.S. population is aging, a phenomenon that has important and wide-ranging consequences for both social and health policy.[1] While the elderly population grows, women will be particularly affected due to the greater proportion of elderly women than men. Currently, women in the U.S. constitute 59 percent of the population over age 65 and 71 percent of the population over age 85. It is estimated that in 30 years, the 65 plus population will double and one in four American women will be over the age of 65. (Fig. 1)

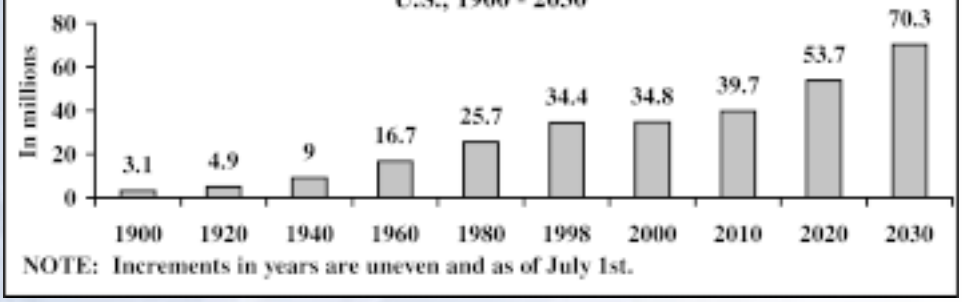
As with national trends, the aging phenomenon is also occurring in Kentucky. 2000 census data indicate that 12.5 percent of Kentucky's population is 65 years of age or older. Of this population, women make up the majority at 57.8 percent. The ratio of women to men increases significantly as they grow older. In Kentucky, 73 percent of persons 85 and older are women. [2]

The mature and older population in Kentucky is the fastest growing segment of the total population. While Kentuckians aged 45 and over grew a modest 0.7 percent from 1980 to 1990, their rate of growth jumped to 9.6 percent from 1990 to 2000. Looking at specific age groups within this population provides a better indication of where the growth is occurring. During the 80s, the largest population growth among the 45 and up population occurred among those aged 75 and over. While this age group continued increasing as a proportion of the total population, the 45 - 54 year age group (otherwise known as "babyboomers") increased by 46.2 percent between 1990 and 2000, which is by far, the largest increase among the mature and elderly population. (Fig. 2)

Menopause

With the average female lifespan increasing from age 48 in the early 1900s to 79 by 2000, women can expect to live at

Figure 1.
Number of Persons Age 65+,
U.S., 1900 - 2030



NOTE: Increments in years are uneven and as of July 1st.

SOURCE: U.S. Census Bureau

least one-third of their lives postmenopausal. Menopause generally occurs in women between the ages of 50 to 55, sometimes earlier. Menopause has three stages: perimenopause, menopause, and postmenopause.

Perimenopause begins two to five years before menopause when the ovaries begin to produce less estrogen. During this time, menstrual cycles may become irregular, or flow may change. About 75 percent of women experience hot flashes, night sweats, vaginal dryness, and/or mood swings during perimenopause.[3] (Fig. 3)

The onset of menopause is characterized by the body's continuing reduction in its production of estrogen, until finally, the menstrual cycles stop altogether. If a woman does not get a period for 6 or more months, she is probably in menopause. Postmenopause, the one to five years following menopause, is the time the body begins to experience the more damaging effects associated with estrogen loss, such as increased risk for certain diseases, including osteoporosis and heart disease.

Cardiovascular Disease Among Postmenopausal Women

Heart disease is more prevalent among postmenopausal women than younger women, and is the leading cause of death among women in Kentucky and the U.S. In fact, cardiovascular disease alone outnumbers the next 16 causes of death to women combined. One in nine women aged 45 to 65 develops heart disease; this rises to one in three women after age 65.[4] After age 50, women develop and die from heart disease at a rate equal to men.[5] In 1999, more women than men died from heart disease in Kentucky: 7,284 female deaths versus 6,873 male deaths. The crude rate of death for women in Kentucky in 1999 was 312.9 deaths per 1,000 women, while the rate for men was 310.1. More women than men die from heart disease primarily because there are more elderly women than men. When adjusting for age, the rate of death for heart disease is higher for men than women, however the gap narrows as women age.[6] (Fig. 4)

Another significant change that often occurs as we age is a gradual decrease in bone density. After menopause, bone loss accelerates because of the

Figure 2.
Mature and Older Adult Population of Kentucky by Age
1980, 1990, & 2000

Age	1980	%	1990	%	2000	%	% Change 1980-1990	% Change 1990-2000
45-54	354,252	9.7	380,872	10.3	556,932	13.8	7.5	46.2
55-64	332,106	9.1	322,562	8.7	372,595	9.2	-2.9	15.5
65-74	248,988	6.8	267,390	7.3	273,943	6.8	7.4	2.5
75-84	125,804	3.4	151,960	4.1	172,589	4.3	20.8	13.6
85+	35,036	1.0	45,718	1.2	58,261	1.4	30.5	27.4

SOURCE: Kentucky State Data Center, 2000 Census

Figure 3.
Consequences of Estrogen Loss

Symptoms (early)	Physical Changes (inter-mediate)	Diseases (later)
Hot flashes	Vaginal atrophy	Osteoporosis
Insomnia	Stress (urinary) incontinence	Cardiovascular disease
Irritability	Skin atrophy	Dementia of the Alzheimer's type
Mood Disturbances		Cancers

SOURCE: *Confronting Aging and Disease: Aging of Women*

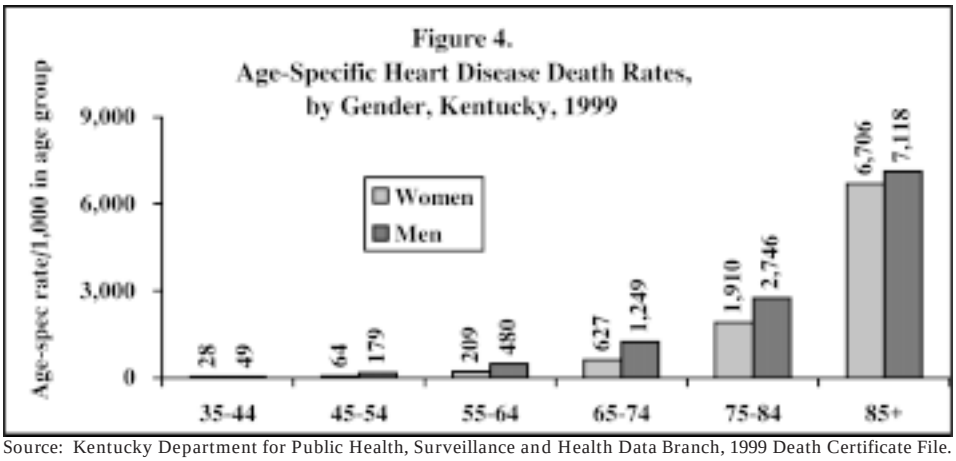
decline in estrogen, which accounts for the increased number of older women affected by osteoporosis. Osteoporosis refers to the condition where the loss of bone mass and strength takes place at a very high rate, resulting in a significant increase in the risk of bone fractures.[7]

Four out of five victims of osteoporosis are women who often are not diagnosed until after a fracture occurs.[8] Osteoporosis is responsible for 70 percent of the fractures that occur in older adults. More than 12 percent of women over 60 years of age sustain a hip fracture; 15 to 20 percent of these women die as a result of their injury.[9]

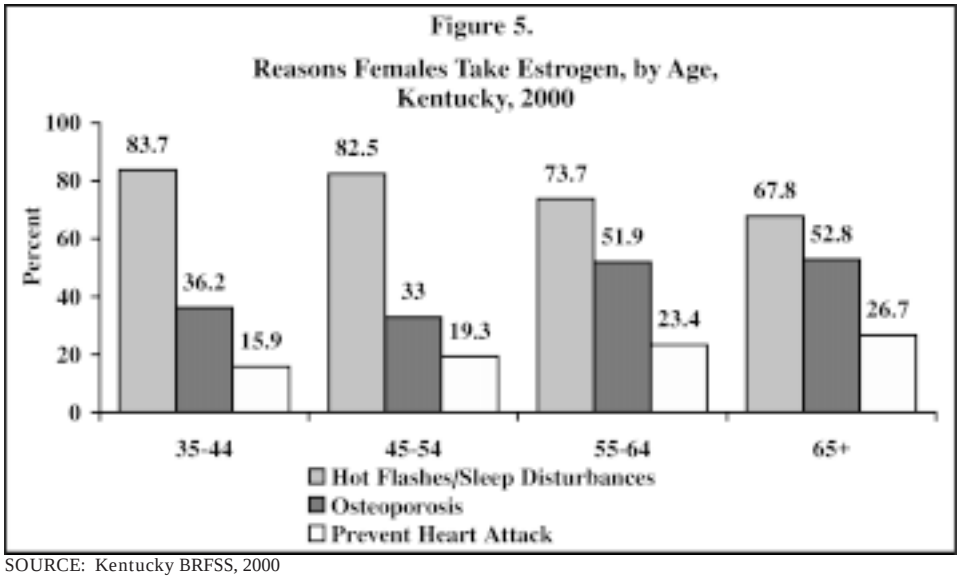
Hormone Replacement Therapy

Replacing estrogen in the postmenopausal woman has been proven effective in the treatment of not only the non-threatening physical symptoms of menopause, but also to protect some women who are at risk for more serious conditions such as heart disease and osteoporosis. Hormone Replacement Therapy (HRT) has been documented for several decades to be an effective remedy for the hot flashes and sleep disturbances that often accompany menopause. While HRT was initially used to reduce the minor discomforts, studies have provided evidence that it may prevent or reduce some of the negative long-term health effects of menopause.[10] (Fig. 5)

According to the 2000 BRFSS, approximately 61 percent of Kentucky women aged 35 and over, who have had a hysterectomy, or are menopausal or postmenopausal, said their doctor had discussed the benefits and risks of estrogen with then. The majority of Kentucky women over age 35 that have had a hysterectomy or



Source: Kentucky Department for Public Health, Surveillance and Health Data Branch, 1999 Death Certificate File.



SOURCE: Kentucky BRFSS, 2000

are menopausal or postmenopausal, or are taking HRT (Fig. 6).

Although HRT has potential benefits for many menopausal and postmenopausal women, it can also have drawbacks. Concerns about HRT center on the increased risk of uterine cancer and breast cancer, especially after long-term use (more than 10 years).[11]

Women with a family or personal history of breast cancer may be at increased risk of cancer when taking HRT. Though breast cancer is often perceived as a younger woman's issue, the majority of breast cancers are diagnosed in women over the age of 50, making increased age one of the primary risk factors.[12] (Fig. 7)

HRT may also not be appropriate for women with a family or personal history of ovarian cancer. Ovarian cancer affects fewer women than many other cancers, however, the difficulty in detecting the cancer in the early stages makes it harder to treat and more deadly. Age is also a risk factor for ovarian cancer with half of all ovarian cancer cases occurring in women over the age of 65.[13]

Alzheimer's Disease and Dementia

Alzheimer's disease is a degenerative brain disease that usually begins gradually, causing a person to forget recent events or familiar tasks. How rapidly it advances varies from person to person, but the brain disease eventually causes confusion, personality and behavior changes, and impaired judgment. (Fig. 8)

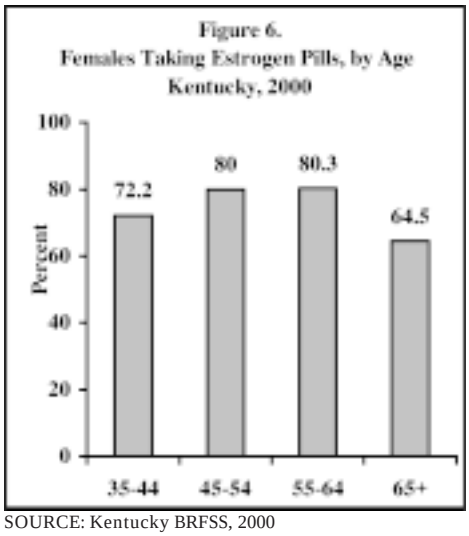
Communication becomes difficult as the affected person struggles to find words, finish thoughts, or follow directions. Eventually, most people with Alzheimer's disease become unable to care for themselves.[14]

One in 10 people over the age of 65 and almost half of those over the age of 85 have Alzheimer's disease. According to the National Alliance for the Mentally Ill, four million Americans have Alzheimer's disease and unless a cure or prevention is found, that number will jump to 14 million by the year 2050. Worldwide, it is estimated that 22 million individuals will develop Alzheimer's disease by the year 2025.

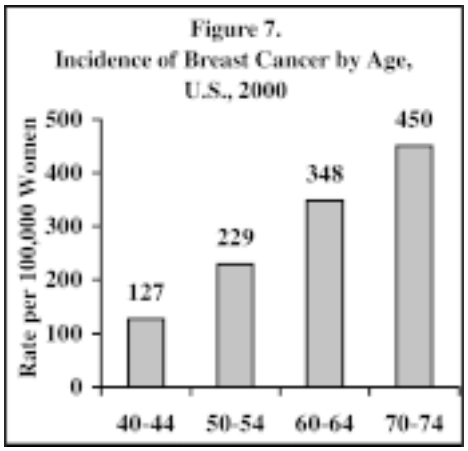
Alzheimer's disease touches many people's lives, young or old. In a national survey, 19 million Americans said they have a family member with Alzheimer's disease, and 37 million said they knew someone with the disease.[15]

Kentucky has several state-wide programs aimed at relieving some of the burden associated with Alzheimer's disease. Adult Day and Alzheimer's Respite programs, long-term care ombudsman programs, the state health insurance information and assistance program (SHIP), and the personal care attendant program are administered by the Kentucky Office of Aging Services through the Area Agencies on Aging and the aging network.

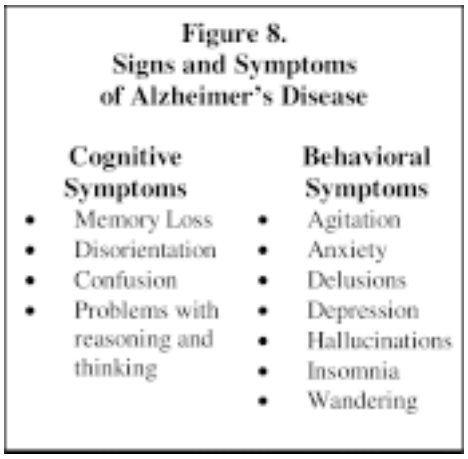
Dementia, one of the most commonly identified symptoms of Alzheimer's, is a disorder that impairs the vascular or neurologic structures of the



SOURCE: Kentucky BRFSS, 2000
* Women over age 35 that have had a hysterectomy or are menopausal or postmenopausal, or are taking HRT



SOURCE: Genetic Health, *Breast and Ovarian Cancer: Nongenetic Risk Factors*, September 5, 2000



SOURCE: Alzheimer's Association, *People with Alzheimer's Disease Frequently Asked Questions*

brain. Short-term memory loss, confusion, and the inability to think problems through or complete tasks without step-by-step instructions characterize dementia.[16] A few causes of dementia are treatable, including normal pressure hydrocephalus, brain tumors, and dementia due to metabolic causes. However, many of the disorders associated with dementia, such as Alzheimer's, are progressive, irreversible, degenerative conditions.[17]

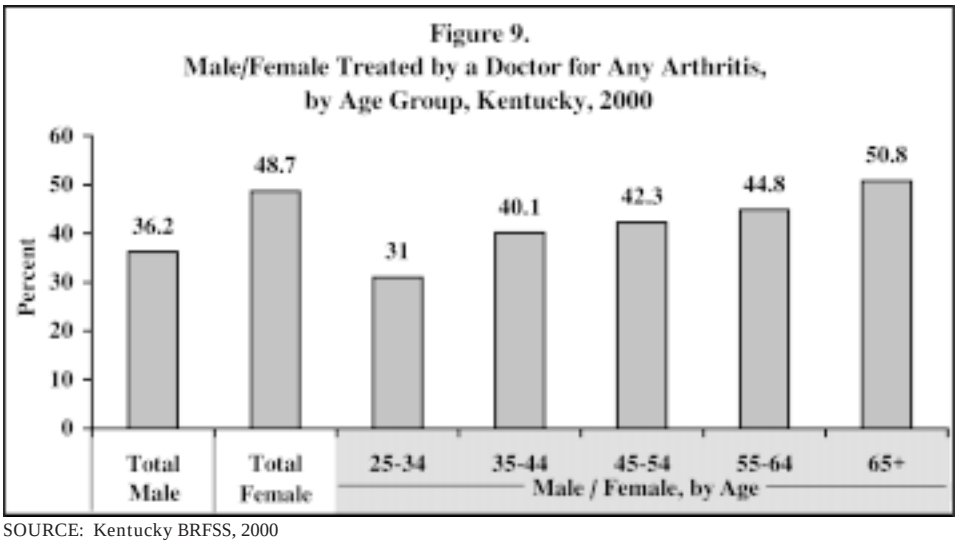
Dementia is a medical, social, and economic problem. It is becoming increasingly significant as the number of elderly continue to rise. Dementia is rare before the age of 65, but the risk increases with advanced age. The chances of being affected are fewer than 1 in 1,000 under the age of 65, 4 to 5 in 100 over the age of 65, and 1 in 5 over the age of 80.[18]

Rheumatic Diseases

An estimated 40 million people in the United States have arthritis or other rheumatic conditions. By the year 2020, this number is expected to reach 59 million. Rheumatic diseases are the leading cause of disability among adults aged 65 and older, yet affects people of all races and ages. Many of these conditions affect women more than men. For example, rheumatoid arthritis occurs two to three times more often in women than in men. Scleroderma is more common in women than in men. Nine out of 10 people who have lupus are women, with African-American women three times more likely than Caucasian women to have the disease.[19]

For women and men in Kentucky who have been told by a doctor that they have arthritis, more women than men receive treatment, particularly as they age.[20] (Fig. 9)

Figure 9.
Male/Female Treated by a Doctor for Any Arthritis, by Age Group, Kentucky, 2000



SOURCE: Kentucky BRFSS, 2000

Hearing and Vision Loss

Age-related hearing loss (presbycusis) is a common phenomenon among the aging. At least 25 percent of individuals over the age of 65 report problems with hearing. Hearing loss is a common and potentially disabling problem in older adults. While approximately one-quarter of the elderly complain of hearing problems; at least one-third have significant hearing impairment on audiological testing. Hearing loss may impair physical and social function, and is associated with cognitive deficits, mood disturbances and behavioral disorders.[21]

By the age of 65, approximately one in three persons has some form of vision reducing eye disease. The most common causes of vision loss among the elderly are age-related macular degeneration, glaucoma, cataract and diabetic retinopathy. Age-related

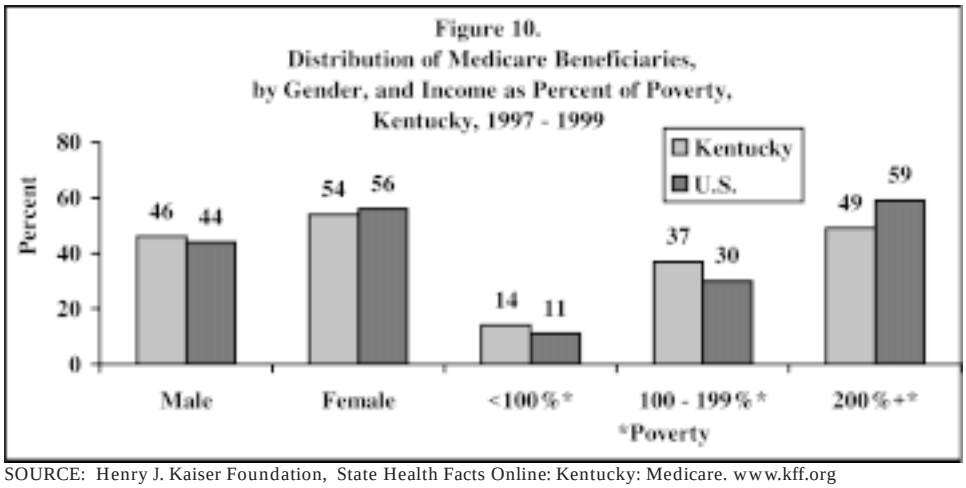
macular degeneration is characterized by the loss of central vision. Glaucoma may result in optic nerve damage and visual field loss. Because this condition may initially be asymptomatic, regular screening examinations are recommended for elderly patients.

Cataract is a common cause of vision impairment among the elderly, but surgery is often effective in restoring vision. Diabetic retinopathy may be observed in the elderly at the time of diagnosis or during the first few years of diabetes. Patients should undergo eye examinations with dilation when diabetes is diagnosed and annually thereafter.[22]

Health Care Access and Services

As the mature and elderly population continues to grow over the next 20 to 30 years, Kentucky's health care delivery system will be challenged to provide adequate health services and programs. Likewise, the needs of this population will drive important policy decisions regarding the distribution and use of public resources.

An influential factor in the health of the elderly is having access to and being able to afford the cost of healthcare. The federal Medicare program provides health insurance coverage for nearly one in five adult women in the United States (19%), primarily those ages 65 and older.[23] Given women's longer life span, they rely on Medicare for more years than men and are disproportionately represented among beneficiaries aged 85 and older.[24] Nationally, women



SOURCE: Henry J. Kaiser Foundation, State Health Facts Online: Kentucky: Medicare. www.kff.org

account for more than 57 percent of the total Medicare population and 71 percent of Medicare beneficiaries over 85.[25]

In Kentucky, 16 percent (615,436) of the total population were enrolled in Medicare (1999 data). Of those receiving Medicare benefits, 86 percent were the elderly over age 65 and 54 percent were females.[26] (Fig. 10)

While Medicare provides coverage for basic acute care services, it has high cost-sharing requirements and does not cover outpatient prescription drugs. Many Medicare beneficiaries have supplemental insurance to help alleviate the out of pocket expenses, 60 percent for both men and women.[27] However, with seven out of 10 Medicare beneficiaries with incomes below the poverty level being women, many cannot afford the cost of supplemental insurance and are faced with high out of pocket expenses for uncovered services. In Kentucky, 51 percent of all Medicare beneficiaries are low-income, living below 200 percent of the federal poverty level.[28]

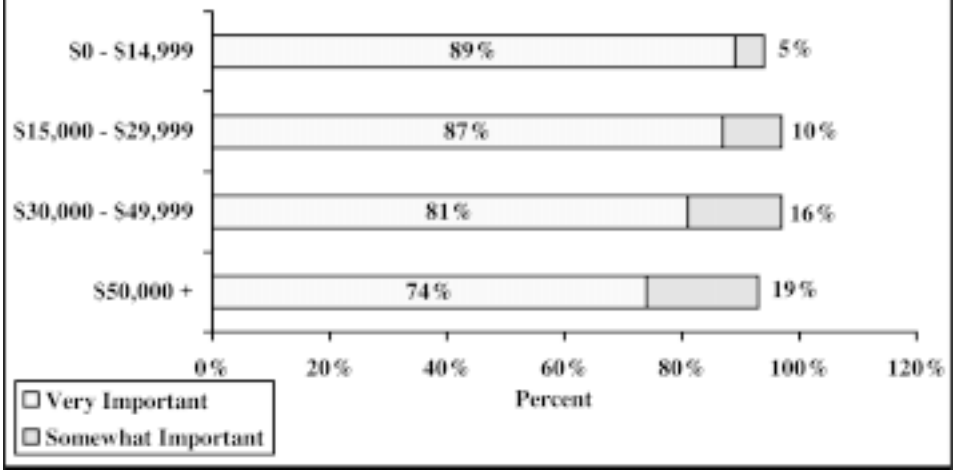
One of the major out-of-pocket expenses facing seniors

Figure 11.
Estimated Medical Expenses for Kentucky Retirees, by Income, 2000

Income Category	Monthly Median Expenses	Median Annual Expenses	Median Annual Expenses As % of Income
$0 - $14,999	$237	$2,844	28 – 38%
$15,000 - $29,999	$300	$3,600	14 – 18%
$30,000 - $49,999	$200	$2,400	06 – 08%
$50,000 +	$200	$2,400	2.6 – 3.4%

SOURCE: Kentucky Long-Term Policy Research Center, UK Sanders-Brown Center on Aging, and UK Survey Research Center, *Policy Notes*, August 2001

Figure 12.
Percent of Kentuckians who say government support for prescription drug coverage is very or somewhat important, by income and age 45+, 2000



SOURCE: Kentucky Long-Term Policy Research Center, UK Sanders-Brown Center on Aging, and UK Survey Research Center, *Policy Notes*, August 2001

today is the cost of prescription medication. Medicare does not pay for prescription drugs and as a result, many elderly go without the medicines they need. A 1999 RAND Corporation study found that insurance alone cut the portion of household income spent on prescription drugs in half. On average, the study found lower income seniors shouldered a cost burden three times higher than that of middle-income seniors and 10 times that of higher-income seniors. Those with one or more chronic conditions had burdens three times greater than those without them.[29]

Kentucky seniors face the same challenges as the elderly nationwide. Surveys in Kentucky indicate that almost three-quarters of Kentucky retirees with an annual income of $15,000 or less say they cannot afford all of their medical expenses, which account for 28 - 38 percent of their total income. (Fig. 11) Of Kentucky retirees with an annual income of $50,000 or more a year, one-third say that they cannot afford all of their medical expenses. Overall, more than half (52%) of retirees in Kentucky report not being able to afford all of their medical expenses.[30] Like wise, the majority of Kentuckians aged 45 and over, particularly those among lower income groups, say government support for perscription drug coverage is very or somewhat important. (Fig. 12)

Of female Medicare beneficiaries nationally, 17 percent have incomes below the federal poverty level compared to 11 percent of men. [31] Given women's disproportionately low incomes and greater need for long-term care, female Medicare beneficiaries are more likely than males to rely on Medicaid (the joint federal / state health program) to fill in Medicare's gaps.[32]

Medicaid provides two very important benefits to qualifying elderly: outpatient prescription drug coverage and long-term care services. Because women spend approximately 22 percent of their incomes on healthcare versus 17 percent for men,[33] these benefits provide a safety net for poor women. The financial burden for out-of-pocket healthcare costs is highest for poor women without Medicaid. Nationally,

nearly 10 million women with incomes below twice the poverty level, are not on Medicaid. These women are spending over half of their incomes on medical care.[34]

Medicaid also covers long-term care services to eligible recipients residing in a licensed, certified nursing facility. In 1998, 11 percent of Kentucky's Medicaid enrollment were elderly with spending for this group representing 24 percent of all Medicaid spending.[35] The majority of this spending is for long-term care for the elderly. In fact, Medicaid was the primary payor source for over 71 percent of nursing facility beds in 1999. Private pay followed at 16.5 percent, with Medicare paying for 9.5 percent. (Fig. 13)

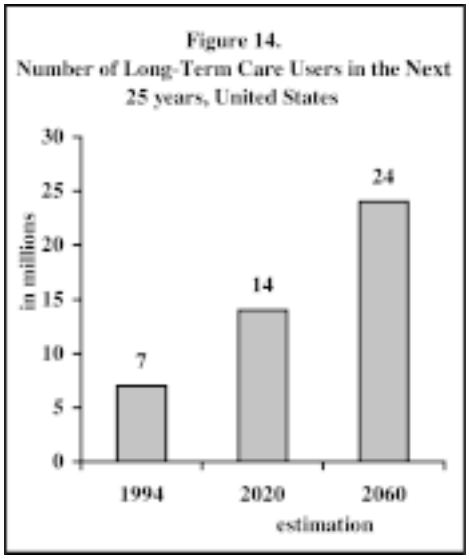
Long-Term Care/Nursing Home Utilization

Women, because of their longer life span, are likelier than men to live with functional impairments necessitating a need for long-term care. Nationally, two-thirds of all Medicare beneficiaries who receive home health services and three-fourths of all nursing home residents are female.[36]

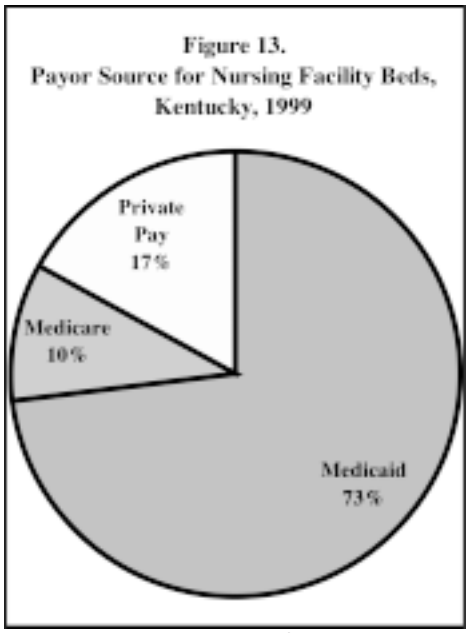
Long-term care is necessary when a chronic condition, trauma, or illness limits their ability to carry out basic self-care tasks, often called activities of daily living (ADLs), or household chores, known as instrumental activities of daily living (IADLs). An estimated 12.8 million Americans of all ages need assistance from others to carry out everyday activities. Most, but not all, persons in need of long-term care are elderly. Approximately 57 percent are persons aged 65 and older; 40 percent are working-age adults aged 18 to 64; and 3 percent are children under age 18.[37]

The 21st century will be marked by a dramatic increase in the size of the older population as the large baby boom generation ages. It is estimated that the number of older persons needing long-term care may as much as double over the next 25 years.[38] (Fig. 14)

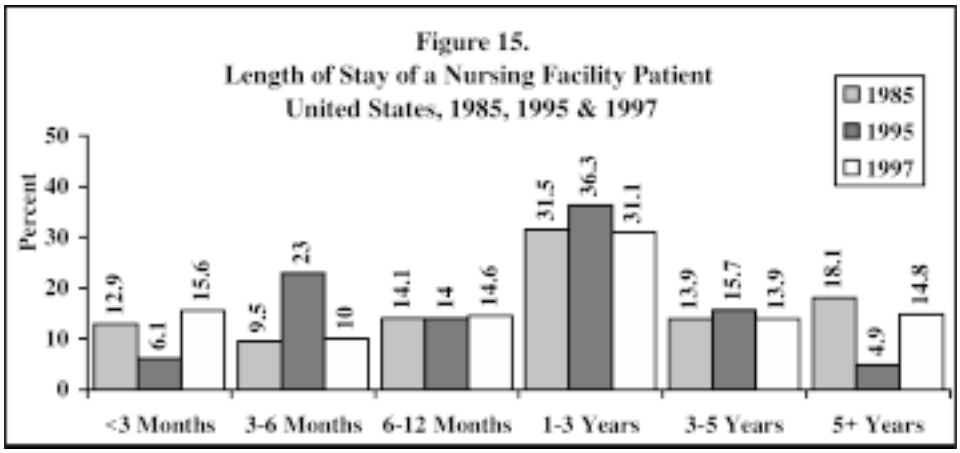
Nationally, nursing home stays were shorter in 1997 than a decade earlier, perhaps reflecting more use of home health care or the use of nursing homes for short-term rehabilitation.[39] (Fig. 15) The average length-of-stay (admission to discharge) for nursing facility patients is 870 days (2.38 years). This figure is higher for female patients at 907 days (2.48 years). The number of days spent in a nursing facility appears to increase with age. Persons aged 65 to 74 spend approximately 857 days in a nursing facility while persons over the age of 85 have been in the facility an average of 932



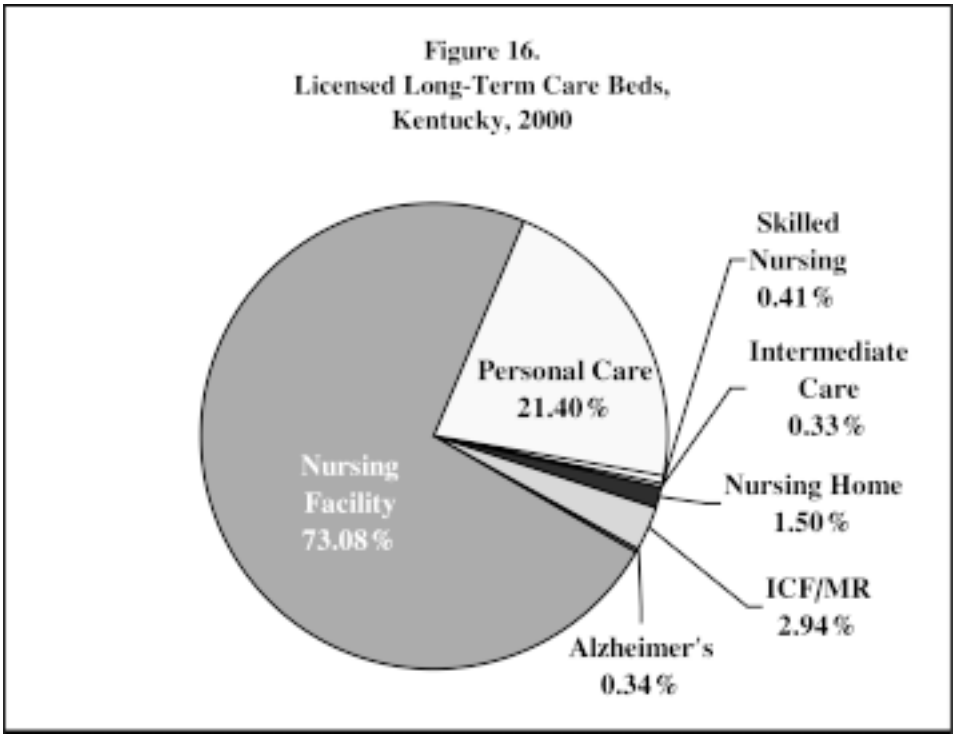
SOURCE: U.S. General Accounting Office, *Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages*, (GAO / HEHS-95-26), November 7, 1994



SOURCE: Kentucky Department for Public Health, Health Policy Development Branch, *1999 Kentucky Long Term Care Report*



SOURCE: National Center for Health Statistics, National Nursing Home Survey: 1985, 1995, and 1997



SOURCE: Kentucky Department for Public Health, Health Policy Development Branch, *2000 Kentucky Long Term Care Report*

days (2.55 years). Single persons (widowed, divorced, or never married) are likely to spend significantly more days in a nursing facility than their married counterparts.[40]

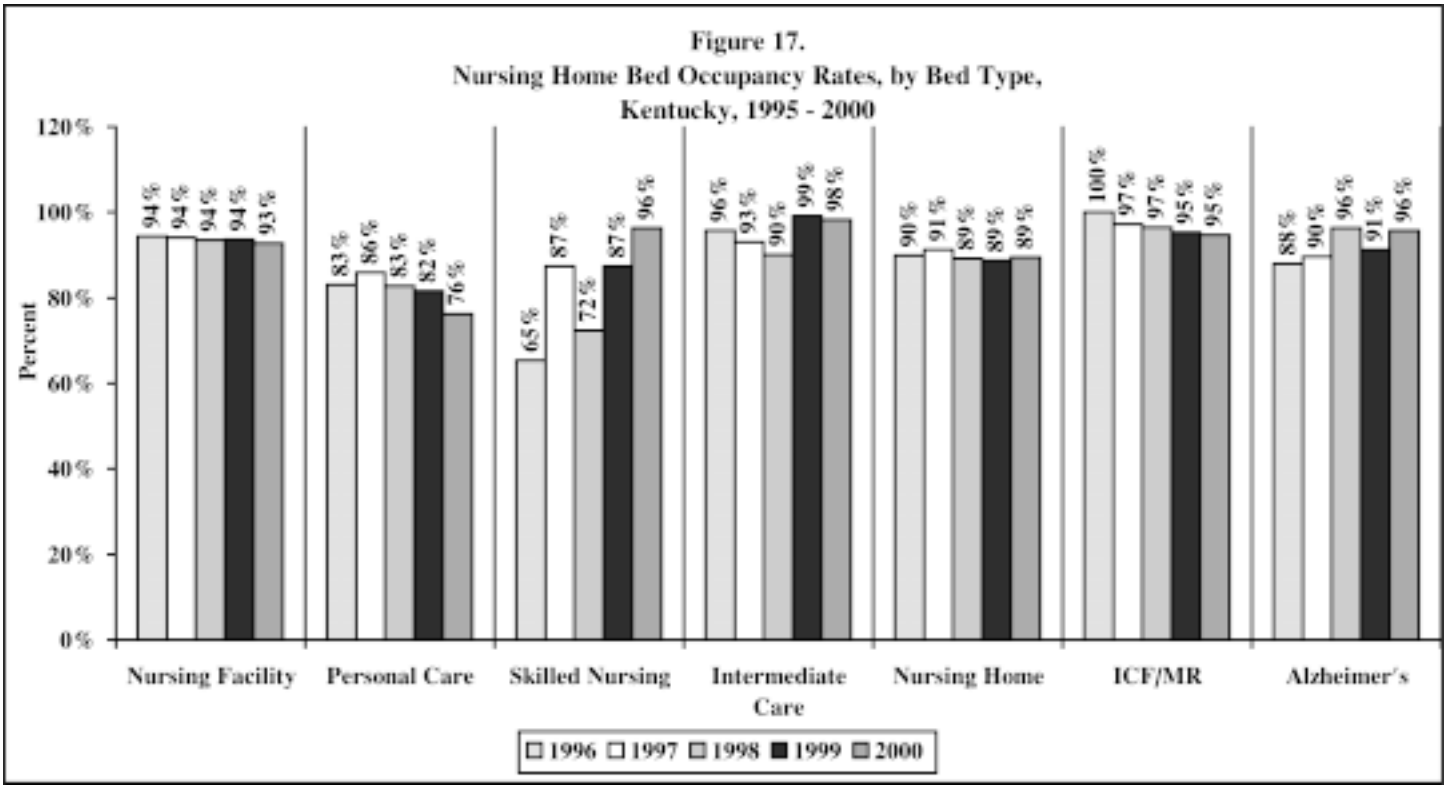
In 2000, Kentucky had 25,553 licensed nursing home beds. Most of these beds, 73 percent, are licensed as nursing facility (NF) beds. Personal care beds make up the second largest category with 21.4 percent. (Fig. 16)

In Kentucky, nursing home occupancy rates have fluctuated over the past six years, yet remain consistently high. (Fig. 17) Looking at occupancy rates by region, most areas of the state experienced a decline in occupancy since 1995, while only three regions, FIVCO, Lake Cumberland and Bluegrass saw increases. (Fig. 18)

For the elderly not needing the level of care provided by nursing homes and other institutions, Kentucky offers a Homecare Program. Homecare is a social service rather than a medical service, where no doctor's order is necessary. In-home services offered by this program include patient assessment, case management, escort services, home-delivered meals, homemaker, chore, home repair and home management services, personal care, and respite care.

Caregiver Issues

Over the next decade approximately 47 million baby boomers in North America will be facing the role of caregiver to a parent, relative or elderly friend. At the same time countless thousands of seniors face the dilemma of

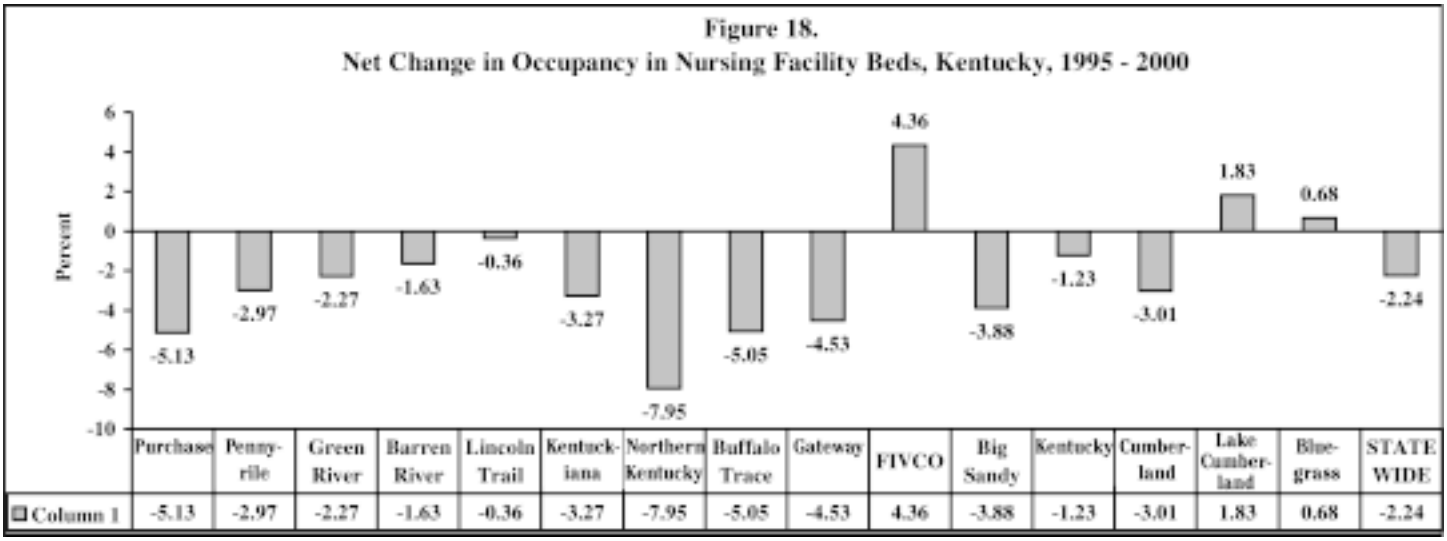


SOURCE: Kentucky Department for Public Health, Health Policy Development Branch, *1995 - 2000 Kentucky Long Term Care Reports*

caring for a chronically ill spouse.[41]

The typical caregiver in this country is a married woman in her mid-forties who works full-time, is a high school graduate, and has an annual household income of $35,000. (Fig. 19) Asian and Hispanic caregivers are younger than whites, with average ages of 39 and 40, respectively, compared with 47 for whites. More than one-third of Asian and Hispanic caregivers are under 35, compared with just over one in five white caregivers. More than 73 percent of the caregivers are female and 27 percent are male.[42]

While there are numerous reasons for a person needing caregiving, aging is the most commonly cited purpose.



SOURCE: Kentucky Department for Public Health, Health Policy Development Branch, *1995 - 2000 Kentucky Long Term Care Reports*

Functional impairments such as mobility problems and dementia are also commonly cited. (Fig. 20)

Another phenomenon occurring among the mature and elderly population is grandparenting, or grandparents raising grandchildren. According to the 2000 census, nearly 5.5 million children live with grandparents. In three-fourths of the families with grandparents and grandchildren, a grandparent maintains the household. These grandparents are not always seniors, but many of them fit into this category. Of the grandparents who are 65 years of age and older, 15 percent are women; 21 percent are men.[43]

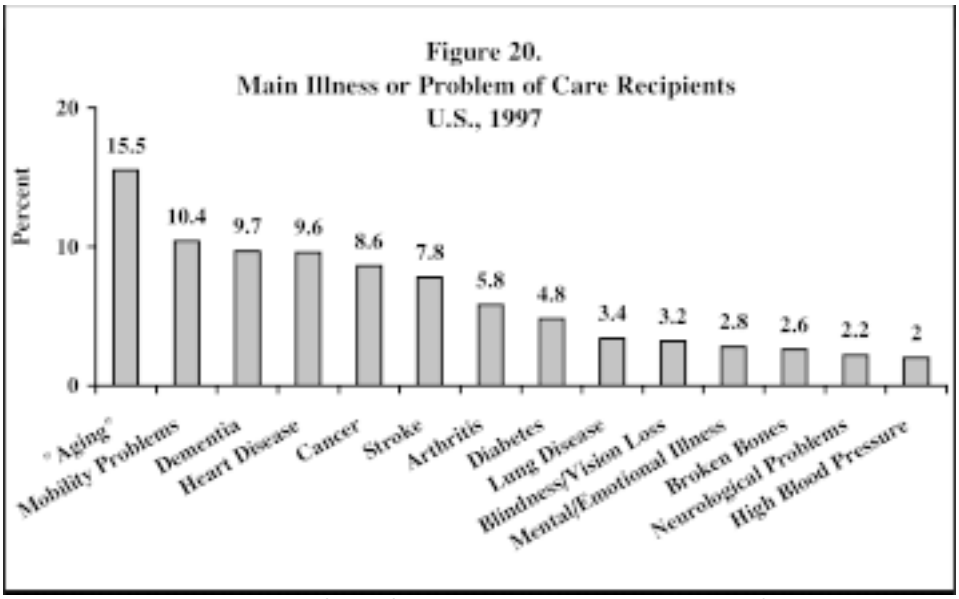
Kentucky is in the process of developing a program to coordinate a system of support for family caregivers of older adults and grandparents caring for children under the age of 18. For more information on this program, contact the Kentucky Office of Aging Services.

Figure 19.
Caregiver Profile

	White	Black	Hispanic	Asian
Gender				
Female	73.5	76.8	67.4	52.3
Male	26.5	23.2	32.6	47.7
Age of Caregiver				
< 35	20.5	23.5	37.1	38.6
35-49	39.0	44.4	37.5	43.6
50-64	26.8	22.5	21.2	14.4
65 or Older	13.6	9.5	4.2	3.4
Mean (years)	47	45	40	39
Marital Status				
Married or living with partner	67.8	50.9	63.8	64.4
Single, never married	11.1	19.3	18.2	26.1
Separated or divorced	12.1	19.0	15.7	6.0
Widowed	8.3	9.8	2.0	3.0
Children <18 years of age in Household				
Yes	38.8	51.0	58.3	51.1
No	60.2	48.4	41.7	48.1
Educational Attainment				
< High School	8.2	16.3	11.1	2.3
High School Graduate	36.0	32.0	35.2	18.2
Some College	22.2	26.8	26.7	17.0
College Graduate	20.4	15.4	18.2	39.0
Graduate School	8.8	5.6	6.5	20.8
Technical School	3.5	3.3	2.3	1.9
Current Employment				
Full Time	51.0	55.6	51.8	63.3
Part Time	12.7	10.5	13.4	14.0
Retired	17.0	13.7	6.8	4.2
Not Employed	18.9	20.3	28.0	18.2
Household Income				
< $15,000	11.7	29.1	21.1	8.3
$15,000 - $24,900	17.3	24.8	22.5	11.0
$25,000 - $29,900	9.5	9.8	7.8	8.0
$30,000 - $39,900	14.0	12.4	16.3	13.3
$40,000 - $49,900	10.4	7.8	11.1	14.0
$50,000 - $74,900	14.4	9.5	10.4	15.5
$75,000 or higher	12.1	3.0	6.2	19.7
Median	$35,000	$22,500	$27,500	$45,000

SOURCE: *Family Caregiving in the U.S. findings from a National Survey*, The National Alliance for Caregiving and The American Association of Retired Persons, June 1997

Figure 20.
Main Illness or Problem of Care Recipients
U.S., 1997



SOURCE: *Family Caregiving in the U.S. findings from a National Survey*, The National Alliance for Caregiving and The American Association of Retired Persons, June 1997

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